

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04893

138  
Be  
Reg. Dist. No. 74

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 5 days

## 3. (a) FULL NAME

Lawrence Paul Beere

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) unknown 1915

8. AGE: Years 32 Months Days If less than one day hrs. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Painter

## 11. Industry or business

MOTHER FATHER 12. Name Martin Beere

13. Birthplace Germany

14. Maiden name May E. Weber

15. Birthplace Maryland

16. Informant Hospital Records

Address

Burial, cremation, or removal? June 30 47  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Baltimore Md.

18. Funeral director John A. Moran

Address 3000 E. Balto. St.

19. June 28 1947  
(Date rec'd by registrar) C. Harry Eeers  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3113 East Preston Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 22 1947 to June 27 1947

and that I last saw h. im alive on June 27 1947

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions

I Chronic Alcoholism

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

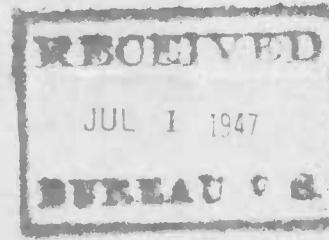
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichert, M.D.

M.D. or other

Address Springfield State Hosp., Sykesville, Md. Date signed 6-27-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04894

93d

76

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Carroll

City or town..... Rural Westminster  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Clara Smith Billingslea

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Carroll

City or town..... Rural Westminster  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Route 7

(If rural, give LOCATION)

2.(a) If veteran, name war..... none

## 3. (b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

8.(b) Name of husband or wife..... Charles Billingslea

7. Birth date of deceased (mo., day, yr.)..... February 20, 1856

8. AGE: Years 91 Months 3 Days 29 If less than one day hrs. min.

9. Birthplace..... Wakefield, Md.  
(Town, county, and state)

10. Usual occupation..... none

11. Industry or business

12. Name..... John Smith

13. Birthplace..... Maryland

14. Maiden name..... Caroline Cookson

15. Birthplace..... Maryland

16. Informant..... Susan H. Billingslea

Address..... Westminster, Md.

17. burial..... Date thereof..... 6/21/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Westminster Cemetery

Location..... Westminster, Md.

18. Funeral director..... J. Francis Reese

Address..... Westminster, Md.

19. (Date rec'd by registrar)..... 6/20/47 Address..... Greenwood  
Registrar..... Greenwood

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 18 1947 at 5:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9th 1947 to June 18 1947

and that I last saw her alive on June 18 1947  
Immediate cause of death..... Cystic  
Coronary dilatation DURATION 15 minsDue to..... Chronic myocarditis 1 year  
and arteriosclerosis 2 mos

Due to.....

Other conditions..... Coronary disease. 2 mos

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

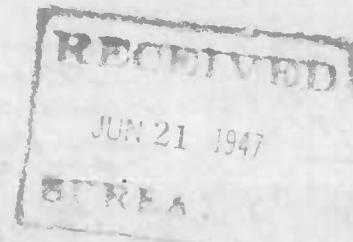
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other.....

Address..... Greenwood

Date signed 6/20/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04895

## CERTIFICATE OF DEATH

46e ✓ Reg. Dist. No. 70

## 1. PLACE OF DEATH:

County: Carroll  
 City or town: Taneytown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death: 50 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs. Alice Buffington

4. Sex: F 5. Color or race: W 6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: James Buffington

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1862 6.(c) If alive, give age: years

8. AGE: Years: 84 Months: 6 Days: 11 If less than one day: hrs: min:

9. Birthplace: Pa. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

12. Name: Henry K. Sherman

13. Birthplace: Pa.

14. Maiden name: Lizzie A. McConnell

15. Birthplace: Pa.

16. Informant: Miss Ida Sherman

Address: York, Pa.

17. Burial: Date thereof: June 7, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Lutheran

Location: Taneytown, Md.

18. Funeral director: C. O. FUSS &amp; SON

Address: Taneytown, Md.

19. June 7, 1947 Ethel M. Medding  
 (Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:  
 City or town: (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4th, 1947, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1st, 1947, to June 4th, 1947, and that I last saw her alive on June 4th, 1947.

Immediate cause of death: Baritonia of sigmoid flexure of colon

DURATION

6 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

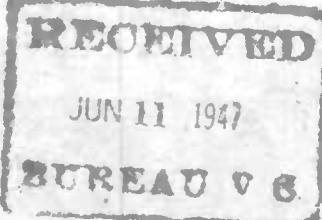
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: b. M. Benner, M.D.

M. D. or other

Address: Taneytown, Maryland Date signed: June 6th, 1947



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04896

## CERTIFICATE OF DEATH

BC Reg. Dist. No. 74

## 1. PLACE OF DEATH:

Carroll County

Henryton City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Maryland.

How long in hospital or institution?

## 3. (a) FULL NAME

DOREATHA CANDY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

colored

married

6.(b) Name of husband or wife

Walter Candy

6.(c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.)

March 11, 1917

8. AGE:

Years

Months

Days

If less than one day

30

2

26

hrs.

min.

9. Birthplace

Nashville, N. C.

(Town, county, and state)

10. Usual occupation

Laundry Worker

11. Industry or business

MOTHER FATHER

12. Name Leroy Boddie

13. Birthplace Unknown

14. Maiden name Emma L. Manning

15. Birthplace Unknown

16. Informant Deceased

Address

Burial, cremation, or removal. When? Skipped

Date thereof 6/12/47

Cemetery or crematory

Location Rocky Mountain N. C.  
Mrs. Kate R. Williams

18. Funeral director

Address 3229 Schröder St.

19. 6/6

19

47

Albert R. Schröder  
Deputy Local

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1428 Mosher St.,

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 6,

19 47 at 10.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 26, 19 47 to June 6, 19 47

and that I last saw her alive on June 6, 19 47.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Feb. 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Nealeen Offman, M.D.

M. D. or other

Address Henryton, Md. Date signed 6/6/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04897

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## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County

Baltimore

City or town

Mix. Aire, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Arthur E. Clay

## 3. (b) Social Security Number

4. Sex

Male Colored Widowed

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Daisy Clay

7. Birth date of deceased (mo., day, yr.)

Jan. 1 1880

6.(c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day  
67 5 17 hrs. min.

9. Birthplace

Penns

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Harry Clay

12. Name

Ohio

13. Birthplace

Clara Stamford

14. Maiden name

Penns

15. Birthplace

Mrs. Clara Rogers

16. Informant

1711 McCullough St. Balt. Md.

Address

Burial

Date thereof 6-20-47

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or cemetery

National

Location

Gettysburg, Penns

18. Funeral director

G. W. Weller

Address

Winnipeg, Man

19. (Date rec'd by registrar)

1947 Apr 18 (Date signed)

VS A15

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Mix Aire (If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 17 1947 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mary 1947 to June 17 1947

and that I last saw him alive on June 17 1947

Immediate cause of death

Coronary Occlusion

DURATION

Sudden

Due to

Hypertension and  
Atheros. myocarditis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

CM Van Park

M. D. or other

Address Mix Aire Md. Date signed 6/18/47

RECEIVED

JUN 20 1947

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04898

## CERTIFICATE OF DEATH

74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

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1. PLACE OF DEATH:  
Carroll

County

Henryton

(If outside city or town limits, write RURAL and give nearest town)

1 year, 9 months.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

3. (a) FULL NAME

JOHN CONRAD COLLINS

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife..... Lottie Collins.

6.(c) If alive, give age..... 39 years

7. Birth date of deceased (mo., day, yr.) February 4, 1903

8. AGE:	Years	Months	Days	If less than one day
	44	4	0	hrs. min.

8. Birthplace..... Baltimore, Md.  
(Town, county, and state)

10. Usual occupation..... Truck Driver

11. Industry or business

12. Name..... Robert Collins

13. Birthplace..... Maryland

14. Maiden name..... Amanda Bedford

15. Birthplace..... Baltimore, Md.

16. Informant..... Mrs. Lottie Collins

Address..... Cambridge, Maryland

17. Burial..... Date thereof..... June 7-1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Baltimore Mem. Park

Location..... Baltimore Co., Md.

18. Funeral director..... Mrs. George A. Stullard

Address..... 1631 Druid Hill Ave.

19. June 4, 1947  
(Date rec'd by registrar)

Deputy Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 16 Pine Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

217-10-8519

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 4, 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 4, 1945, to June 4, 1947.

and that I last saw him alive on June 4, 1947.

Immediate cause of death.....

Septicemia following extraction  
of teeth.

Due to.....

Due to.....

Other conditions..... Pulmonary tuberculosis

Aug.

1945

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

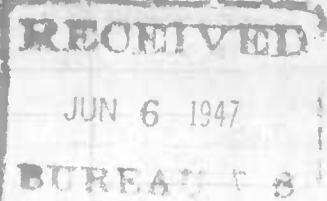
Injured at work?

23. SIGNATURE..... Neelam D. D. D. M. D.

M. D. or other

Address..... Henryton, Md.

Date signed..... 6-4-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04899

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

Carroll

County

Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. 2, box 550

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## 3. (a) FULL NAME

ALMA COLLESTIA COOK

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Colored Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 20, 1931

8. AGE: Years Months Days If less than one day  
16 0 24 hrs. min.9. Birthplace Anne Arundel Co., Md.  
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Sylvester Cook  
13. Birthplace Anne Arundel County, Md.  
14. Maiden name Frances Smith  
15. Birthplace Anne Arundel County, Md  
Frances Smith

16. Informant

Address R.F.D. 2, Annapolis, Md.

17. Burial Date thereof June 17-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadneck Cemetery

Location St. Margaret's, Md.

18. Funeral director J. Johnson

Address Annafield, Md.

19. 6/13 19. 47 (Date rec'd by registrar)

20. Allister Swank  
Deputy Local Registrar

21. M. D. or other

## MEDICAL CERTIFICATION

2d. DATE OF DEATH June 13, 1947, at 7:30 P.M.

2d. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 27, 1947, to June 13, 1947, and that I last saw her alive on June 13, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Jan.

1947

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Neuber Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 6/13/47

RECEIVED

JUN 17 1947

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04900

95c

## CERTIFICATE OF DEATH

Reg. Dist. No. 72

## 1. PLACE OF DEATH:

County Carroll  
City or town Westminster, P.D.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred: (Myers District)

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Jane Crouse

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

John T. Crouse

Dead

7. Birth date of deceased (mo., day, yr.)

June - 19 - 1857

8. (c) If alive, give age years

8. AGE:

Years  
90Months  
0Days  
4If less than one day  
hrs. min.

9. Birthplace

Carroll Co., Md.  
(Town, county, and state)

10. Usual occupation

Retired Housework

11. Industry or business

Retired Housework

12. Name

Richard Singling

13. Birthplace

Carroll Co., Md.

14. Maiden name

Henretta Atter

15. Birthplace

Carroll Co., Md.

16. Informant

Mrs. Elizabeth Brock

Address

Westminster, Md. P.D. 1

17. Burial

Burial

(Burial, cremation, or removal, Which?)

Date thereof June - 16 - 1947  
(month) (day) (year)

Cemetery or crematory

St. Mary's Union Cemetery

Location

Silver Run, Md.

18. Funeral director

J. M. Stewart & Son

Address

Limestone, PA. P.O. A. L.

19. Date rec'd by registrar

Calvin B. Bensert

Registrar

1. PLACE OF DEATH: County <u>Carroll</u> City or town <u>Westminster, P.D.</u> (If outside city or town limits, write RURAL and give nearest town)	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Carroll</u> City or town <u>Westminster, P.D.</u> (If outside city or town limits, write RURAL and give nearest town)
Hospital, institution, or street address where death occurred: <u>(Myers District)</u>	Street No. <u>Myers District</u> (If rural, give LOCATION)
How long in hospital or institution?	2.(a) If veteran, name war

3. (a) FULL NAME Mary Jane Crouse

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife John T. Crouse 8. (c) If alive, give age Dead years7. Birth date of deceased (mo., day, yr.) June - 19 - 18578. AGE: 90 Years 0 Months 4 Days If less than one day hrs. min.9. Birthplace Carroll Co., Md.  
(Town, county, and state)10. Usual occupation Retired Housework11. Industry or business Retired Housework12. Name Richard Singling13. Birthplace Carroll Co., Md.14. Maiden name Henretta Atter15. Birthplace Carroll Co., Md.16. Informant Mrs. Elizabeth BrockAddress Westminster, Md. P.D. 117. Burial Burial

(Burial, cremation, or removal, Which?)

Date thereof June - 16 - 1947  
(month) (day) (year)Cemetery or crematory St. Mary's Union CemeteryLocation Silver Run, Md.18. Funeral director J. M. Stewart & SonAddress Limestone, PA. P.O. A. L.19. Date rec'd by registrar Calvin B. Bensert

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June - 23 1947 at 8:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1947 to June 23 1947and that I last saw her alive on July 3, 1947 to June 23, 1947Immediate cause of death Senile Degeneration DURATION 1947Underlying cause Organic Brain 7/20/47 (dead)Due to Senile DegenerationDue to Senile Degeneration

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

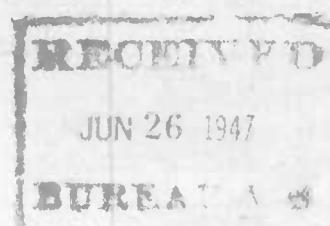
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Stewart M. D. or other 1947Address Westminster, Md. Date signed June 24



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04901

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

1. PLACE OF DEATH:  
Carroll  
County

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

1 month, 25 days

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Maryland.

How long in hospital or institution?

3. (a) FULL NAME

ESTHER MAE DAVIS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	colored	married

6. (b) Name of husband or wife: Joseph Davis

7. Birth date of deceased (mo., day, yr.) Feb., 24, 1915

5. (c) If alive, give age 61 years

8. AGE: Years	Months	Days	11 less than one day
32	4	6	hrs. min.

9. Birthplace: Rock Hill, S. C.

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

12. Name: George Henderson

13. Birthplace: South Carolina

14. Maiden name: Leila Huggins

15. Birthplace: South Carolina

16. Informant: Deceased

Address

17. Burial Date thereof: July 7-47  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: Mrs. G. Kelton

Address: 1803 Restaurant St

19. 6/30 19. 47 Albert R. Samborski  
(Date rec'd by registrar) Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State: Maryland County

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 539 Mission Court

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30, 1947 at 9.50P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1947, to June 30, 1947

and that I last saw her alive on June 30, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Jan. 25 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: Neale Hoffmann, M.D.

M. D. or other

Address: Henryton, Md. Date signed: 6/30/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

## CERTIFICATE OF DEATH

Reg. Dist. No. 040742

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

## 1. PLACE OF DEATH:

County... Carroll  
 City or town... Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Cordelia C. Dixow

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. W. Married

6. (b) Name of husband or wife

Thomas M. Dixow

7. Birth date of deceased (mo., day, yr.)

Sept. 1, 1881

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

65 9 7

hrs.

min.

9. Birthplace

MD  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home Births

12. Name

John Barth

13. Birthplace

Germany

14. Maiden name

Mary M. Wolbert

15. Birthplace

MD

16. Informant

Mr. Thomas M. Dixow

Address

Sykesville, Md.

17. Burial

Date thereof... June 11, 1947  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Morgan Creek Cemetery

Location

M. Woodbine, Carroll Co., Md.

18. Funeral director

C. Harry Dixow

Address

Sykesville, Md.

19. (Date rec'd by registrar)

19. June 12, 1947 C. Harry Dixow

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... CarrollCity or town... Sykesville (If outside city or town limits, write RURAL and give nearest town)

Street No... (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1947 a.m. 4-11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19, 1947 to June 8, 1947and that I last saw Mr. Dixow alive on June 8, 1947

Immediate cause of death

Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

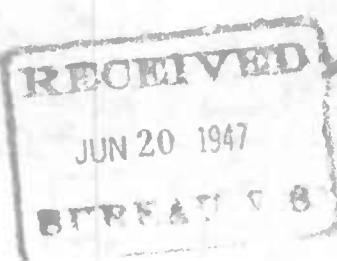
M. A. Barnes MD M. D. or otherAddress... Sykesville, Md. Date signed 6/9/47

RECEIVED

JUN 16 1947

FEDERAL BUREAU OF INVESTIGATION





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04904

50

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County..... Carroll

City or town..... Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 45 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Ruth Matilda Falkenstein

## 3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

married

6. (b) Name of husband or wife

Elwood S. Falkenstein

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

January 13, 1897

8. AGE:

Years

Months

Days

If less than one day

50

4

24

hrs.

min.

9. Birthplace..... York, Penna.

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

MOTHER FATHER

12. Name..... Alexander Diehl

Penna.

13. Birthplace

Emma Beck

14. Maiden name.....

Penna.

15. Birthplace

Rev. Elwood S. Falkenstein

16. Informant.....

Westminster, Md.

Address

17. burial

(Burial, cremation, or removal. Which?)

Date thereof..... 6/9/47

(month) (day) (year)

Cemetery or crematory.....

Greenmount Cemetery

Location.....

York, Penna.

18. Funeral director.....

J. Francis Reese

Address.....

Westminster, Md.

19. (Date rec'd by registrar)

19.....

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 6

19 47 at 6:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 18, 1947, to April 16, 1947

and that I last saw her alive on April 16, 1947

Immediate cause of death.....

Cancer of breast (Breast) extending to lungs 7 months

Due to.....

Due to.....

Other conditions..... metastatic growths in bones &amp; liver, etc.

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

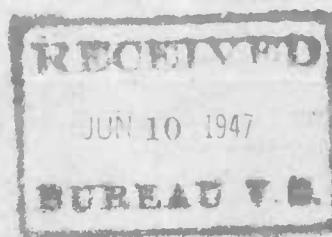
Means of injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Westminster, Md. Date signed 6/9/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04915

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

Carroll

County

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 7 mos. 8 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 9 yrs. 7 mos. 8 days

## 3. (a) FULL NAME

MARJANNA FARYSIAK

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F W Widowed

6. (b) Name of husband or wife Unknown

7. Birth date of deceased (mo., day, yr.) unknown 6. (c) If alive, give age years

1885

8. AGE: Years Months Days If less than one day  
62(?) hrs. min.

9. Birthplace Poland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Record, Springfield State Hospital

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal: Which?) Date thereof (month) (day) (year)

June 13, 1947

Cemetery or crematory Holy Cross Cem.

Location Bel Air Md.

18. Funeral director Leonard J. Rusk

Address 5305 Harford Rd.

19. June 13 1947 C. Harry Wees.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1509 Lancaster Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

DST

20. DATE OF DEATH 6/12 19 47, at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/7 19 47, to 6/12 19 47.

and that I last saw her alive on 6/12 19 47.

Immediate cause of death:

Septicemia, Pneumonia

Due to:

Infection of foot.

Due to:

Diabetes

Other conditions:

Diabetes

Psychosis with convulsive disorder, epilepsy

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arnold H. Eichet, M.D.

M. D. or other

Address Sykesville, Maryland Date signed 6/12/47

RECEIVED

JUN 14 1947

BUREAU of

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04906

## CERTIFICATE OF DEATH

Reg. Distr. No. 75

## 1. PLACE OF DEATH:

County

Carroll

City or town

Lincelton

Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John Warner Fields

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W.

6. (b) Name of husband or wife

Anna M Ellis

7. Birth date of deceased (mo., day, yr.)

June 19-1876

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

71 4 22

hrs.

min.

9. Birthplace

Virginia (town, county, and state)

10. Usual occupation

House

11. Industry or business

Fisher

MOTHER FATHER

12. Name

John B. Fields

13. Birthplace

Virginia

MOTHER

FATHER

14. Maiden name

Elizabeth Holdfield

15. Birthplace

Virginia

16. Informant

Mrs. M. B. Birdsey

Address

Lincelton Md

17. Burial

Date thereof June 14/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Church of God cemetery

Location

Hampstead Md

18. Funeral director

Edgar G. Gifton

Address

Hampstead Md.

19. Date rec'd by registrar

June 12th

1947

M. D. W. R. S. Deamer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

Carroll

City or town

Lincelton - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 11 1947 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

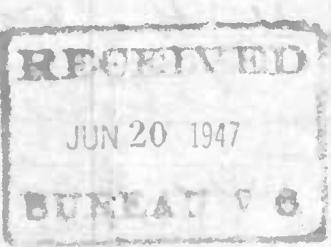
James T. Marsh, Deputy Medical Examiner

M. D. or other

Westminster Md

Date signed

6-11-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04907

Reg. Dist. No. 2X

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 mo 29 da

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

2 mo 29 da

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6. (b) Name of husband

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

7/3/47  
(month) (day) (year)

Cemetery or crematory

Par kwood Cem.

Location

Baltimore, Md.

18. Funeral director

WM. J. TICKNER & SONS  
Balto., Md.

Address

19. (Date rec'd by registrar)

19...

47

St. Hedred

Dm. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3518 Fulton Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 30th 1947

April 2d 1947 to June 30 1947

and that I last saw her alive on June 30 1947

Immediate cause of death

Chronic Hypertension

Due to

Arterio Sclerosis

Due to

Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. J. Weston M.D.

M. D. or other

Address

Date signed

P

04908

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

M  
I  
VS A15  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Carroll  
 County.....  
 City or town..... rural near Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 yr., 1 mo., 29 days  
 Hospital, Institution, or street address where death occurred: Springfield State Hospital  
 How long in hospital or institution? 8 yr., 1 mo., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 195 Welsh Hill  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3.(a) FULL NAME Henry Freel  
 4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife York -  
 7. Birth date of deceased (mo., day, yr.) December 15, 1871  
 6.(c) If alive, give age..... years  
 8. AGE: Years Months Days If less than one day  
 75 5 18 hrs. min.  
 9. Birthplace..... Frostburg, Maryland  
 (Town, county, and state)  
 10. Usual occupation..... miner  
 11. Industry or business coal  
 MOTHER FATHER  
 12. Name..... Hugh Freel  
 13. Birthplace..... Ireland  
 14. Maiden name..... Margaret Gallagher  
 15. Birthplace..... Ireland  
 16. Informant..... Springfield State Hospital records  
 Address..... Sykesville, Maryland  
 17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-6-47  
 (month) (day) (year)  
 Cemetery or crematory..... Frostburg  
 Location..... Frostburg, Md.  
 18. Funeral director..... J. J. Bertrand  
 Address..... Frostburg, Md.  
 19. Date rec'd by registrar) June 4, 1947 C. Harry Webb  
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 3 19 47, at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43, to June 3 19 47, and that I last saw him alive on June 3 19 47.

Immediate cause of death.....  
 Cerebral hemorrhage

Due to..... Arteriosclerosis & hypertension

Due to.....

Other conditions..... Senile Psychosis

8 years

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D.  
 Springfield State Hospital  
 Sykesville, Maryland  
 M.D. or other  
 Address..... Date signed..... 6-3-47

RECEIVED

JUN 6 1947

BUREAU V B

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04909

## CERTIFICATE OF DEATH

Reg. Distr. No. 74

## 1. PLACE OF DEATH:

County CarrollCity or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton, Md.

## 3. (a) FULL NAME

FRANCIS ROMAIN FRIEND4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) February 9, 19128. AGE: Years 35 Months 4 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Federalsburg, Md. (Town, county, and state)10. Usual occupation Shipyard Worker

## 11. Industry or business

12. Name Robert Romain Friend13. Birthplace Maryland14. Maiden name Alice Smith15. Birthplace Maryland16. Informant Deceased

## Address

17. Burial Date thereof June 30 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory FederalsburgLocation Federalsburg Maryland18. Funeral director J. J. Trampton Son.Address Federalsburg Maryland19. 6/26 19. 47 Albert R. DeZoray  
(Date rec'd by registrar) (Date of death) (Name of physician) (Signature)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Federalsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. Preston Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

138-03-0877

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 26, 1947 at 6:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 1947 to June 26, 1947and that I last saw him alive on June 26, 1947Immediate cause of death Pulmonary Tuberculosis DURATION May 1946

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE Reuben W. Holmes, M.D. M. D. or otherAddress Henryton, Md. Date signed 6/26/47

RECEIVED

JUN 27 1947

BUREAU V 6

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164C

04910

## CERTIFICATE OF DEATH

Reg. Dist. No. 15

## 1. PLACE OF DEATH:

County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1.9 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

## 3. (a) FULL NAME

Harry Brian Geiman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M W widowed

6. (b) Name of husband or wife

Leanne Geiman

7. Birth date of deceased (mo., day, yr.)

December 9-1871

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

75

6

6

hrs. min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

Former

11. Industry or business

John Geiman

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

Burial Manchester

17. (Burial, cremation, or removal. Which?) Cemetery

Date thereof 6-18-47

(month) (day) (year)

Cemetery or crematory

St. David York Co. Pa.

Location

West York's Lays

18. Funeral Director

W. H. S. Deemer

Address

Manchester MD

19. June 16<sup>th</sup> 1947 Mrs. W. H. S. Deemer

Registrar

Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 15 1947 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

Immediate cause of death

Gunshot wound of head

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide June 15 1947

Where did injury occur? Manchester Carroll Md.

(City or town) (County) (State)

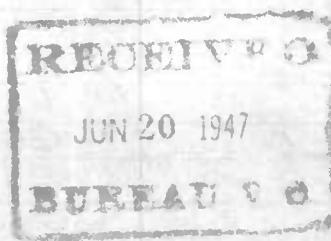
Injured at home, farm, industry, public place (where?) None

Means of injury Gun wound Injured at work? No

23. SIGNATURE

James H. Thorold Deputy Medical Examiner

Address: Westminister Md. Date signed: June 15 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04911  
93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 93

## 1. PLACE OF DEATH:

County

Carroll  
Manchester (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Anna Gertrude Gouds

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife: William Gouds

7. Birth date of

deceased (mo., day, yr.) June 2 - 1862

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

85

- 28

hrs.

min.

9. Birthplace

Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Manchester (Rural)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 29 1947 to June 29 1947

and that I last saw her alive on June 29 1947

Immediate cause of death

Tromic Myocarditis

Due to Generalized Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Mrs. W. P. Deamer M. D. or other

Address Hampstead Md Date signed 6-30-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04912

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yr's, 8 Mo's, 29 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Maryland.

How long in hospital or institution:

## 3. (a) FULL NAME

ARTHUR HOWARD GRAY

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Single

B. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 17, 1923

8. AGE: Years Months Days If less than one day

24 3 1 hrs. min.

9. Birthplace Frederick, Md.

(Town, county, and state)

10. Usual occupation Delivery Boy

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Jeannette Sutton

15. Birthplace Frederick, Md.

16. Informant Deceased

Address

17. Burial Date thereof 6-21-47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location Frederick, Md.

18. Funeral director M. R. Etchison &amp; Son

Address Frederick, Md.

19. 6/18 19 47 (Date rec'd by registrar) Albert B. Schenck, Jr. Deputy Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 149 W. All Saints Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

214-14-6595

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1947, at 6.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20, 1942, to June 18, 1947,

and that I last saw him alive on June 18, 1947.

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Due to

Other conditions Pulmonary Tuberculosis

Aug. 1942

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D. M. D. or other  
Address Henryton, Md. Date signed 6/18/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04913

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
Carroll  
County.....  
City or town..... Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Md  
How long in hospital or institution?

## 3. (a) FULL NAME

Elmore Green

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	married

8. (b) Name of husband or wife..... Mable Green

7. Birth date of deceased (mo., day, yr.)..... October 1, 1921

8. AGE: Years	Months	Days	If less than one day
25	8	7	hrs. min.

9. Birthplace..... Franklinton, N. C.  
(Town, county, and state)

10. Usual occupation..... Chauffeur

## 11. Industry or business

MOTHER / FATHER	12. Name..... Johnnie T. Green
-----------------	--------------------------------

MOTHER / FATHER	13. Birthplace..... Franklinton, N. C.
-----------------	--

MOTHER / FATHER	14. Maiden name..... Hattie B. Burrell
-----------------	--

MOTHER / FATHER	15. Birthplace..... Franklinton, N. C.
-----------------	--

16. Informant..... Deceased

Address..... Burial  
(Burial, cremation, or removal. Which?) Date thereof..... 6-11-47

Cemetery or crematory..... Franklinton

Location.....

18. Funeral director..... Geo. G. Kelton

Address..... 1313 Bostwick St.

19. 6/8 1947

(Date rec'd by registrar) Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 1421 Lafayette Ave.,  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

220-03-1117

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 8, 1947, at 1.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 1947, to June 8, 1947, and that I last saw him alive on June 8, 1947.

## Immediate cause of death.....

Pulmonary Tuberculosis

## DURATION

Feb. 1947

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

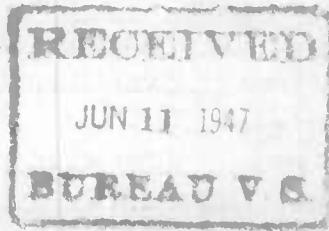
Means of injury..... Injured at work?

## 23. SIGNATURE.....

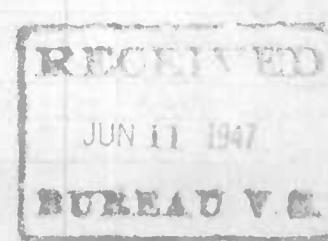
Reuben Hoffman, M.D.

M. D. or other

Address..... Henryton, Md. Date signed..... 6/8/47







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, write the causes of death clearly and legibly. This is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04915

## CERTIFICATE OF DEATH

Reg. Dist. No. 81

## 1. PLACE OF DEATH:

County.....

City or town.....

Carroll Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Colored Widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Dec. 25-1869

8. AGE:

Years

Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation.....

Carroll County Md

11. Industry or business.....

Laborer

MOTHER

FATHER

12. Name.....

not known

13. Birthplace

Baltimore

14. Maiden name.....

not known

15. Birthplace

Baltimore

16. Informant.....

Charles Roberts

Address

Carroll Bridge, Md

17. (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

June 25-47

Cemetery or Cemetery

Mt. Joy Cemetery

Location

Carroll County, Md

18. Funeral director.....

H. H. Hartley &amp; Sons

Address

Carroll Bridge, New Carrollton, Md

19. Date rec'd by registrar

June 24 1947

(Date rec'd by registrar)

V. Cichman

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State..... Maryland County..... Carroll

City or town..... Carroll Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

215-20-9315

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 22 1947 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20 1947 to June 22 1947

and that I last saw him alive on June 21 1947

Immediate cause of death.....

Cerebral Hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

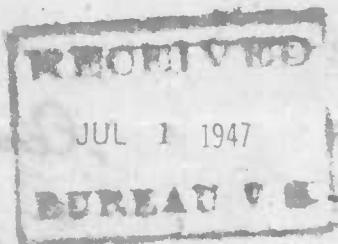
Means of injury..... Injured at work?

23. SIGNATURE.....

J. A. Hegy

M. D. or other

Address..... Union Bridge Date signed..... 6-23-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04916

## CERTIFICATE OF DEATH

Re Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll  
 County: Sykesville  
 City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 years, 2 days  
 Hospital, Institution, or street address where death occurred: Springfield State Hospital  
 How long in hospital or institution? 5 years, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: Maryland County: City  
 City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: 5506 Morello Road (If rural, give LOCATION)  
 2.(a) If veteran, name war: \_\_\_\_\_

3. (a) FULL NAME: Mildred K. Kummer  
 4. Sex: F 5. Color or race: W 6.(a) Single, married, widowed, or divorced: Single  
 6.(b) Name of husband or wife: \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.): 10/3/20 6.(c) If alive, give age: \_\_\_\_\_ years  
 8. AGE: Years: 26 Months: 8 Days: 6 If less than one day: \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace: Baltimore, Maryland (Town, county, and state)  
 10. Usual occupation: None  
 11. Industry or business: \_\_\_\_\_  
 MOTHER FATHER  
 12. Name: Charles A. Kummer  
 13. Birthplace: Baltimore, Maryland  
 14. Maiden name: Nettie Bickel  
 15. Birthplace: Baltimore, Maryland  
 16. Informant: Record, Springfield State Hospital  
 Address: Sykesville, Maryland  
 17. Burial: Burial Date thereof: 6-12-47 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory: Woodlawn Park Cem.  
 Location: Baltimore, Md.  
 18. Funeral director: Leonard J. Rush  
 Address: 3305 Harford Rd.  
 19. Deceased 10 1947 C. Harry Elmer (Date rec'd by registrar) Registrar

3. (b) Social Security Number: \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/9 1947, at 8:15 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/27 1947, to 6/9 1947, and that I last saw h. Dr. alive on 6/9/47 1947.

Immediate cause of death: Pulmonary Tuberculosis DURATION 11/46

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions: Schizophrenia, Simple type (Include pregnancy within 3 months of death) 8 years

Major findings of operations: \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_ PHYSICIAN: Please underline the cause to which death should be charged statistically.

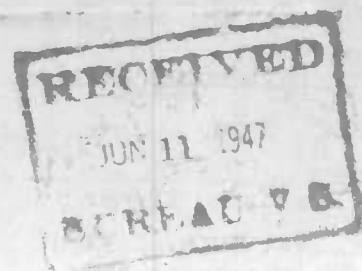
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE: Arnold H. Schild, M.D. M.D. or other: \_\_\_\_\_  
 Address: Sykesville, Maryland Date signed: 6/9/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04917

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County. Carroll  
City or town. Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 7 mos., 5 days

Hospital, institution, or street address where death occurred: Maryland

Tuberculosis Sanatorium

How long in hospital or institution? same as above

## 3. (a) FULL NAME

DIX LEMON

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced  
male      col.      married

6. (b) Name of husband or wife. Susan Lemon

7. Birth date of deceased (mo., day, yr.) April 10, 1897      6. (c) If alive, give age. 34 years

8. AGE:      Years      Months      Days      If less than one day  
50      2      20      ..... hrs.      ..... min.

9. Birthplace. Manning, S.C.  
(Town, county, and state)

10. Usual occupation. laborer

## 11. Industry or business

12. Name. Annison Lemon

13. Birthplace Manning, S.C.

14. Maiden name. Atlee David

15. Birthplace Manning, S.C.

16. Informant. Reuben Hoffman, M.D.

Address. Henryton, Md.

17. Burial. Date thereof. 7/3/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory. Manning

Location. TIC

18. Funeral director. J. S. Brown & Son

Address. 108 W. Montgomery St.

19. June 30, 1947. (Date rec'd by registrar)

136 BC  
2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State. Maryland      County.

City or town. Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1030 S. Sharp St.  
(If rural, give LOCATION)

2. (a) If veteran, name war. World War I

3. (b) Social Security Number  
216-03-9290

## MEDICAL CERTIFICATION

20. DATE OF DEATH. June 30      18. 47      7:20 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 11      19. 44      June 30      10. 47

and that I last saw him alive on June 30      18. 47

Immediate cause of death. Pulmonary tuberculosis      DURATION May 44

Due to.

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings or operations.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.      Date of.

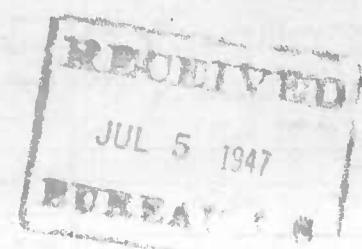
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

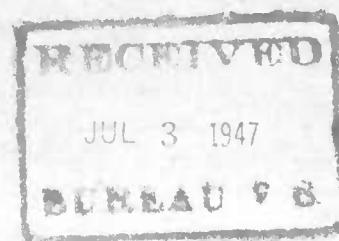
Means of injury      Injured at work?

23. SIGNATURE. Reuben Hoffman, M.D. M. D. or other

Address. Henryton, Md. Date signed. 6/30/47







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04919

97  
Reg. Dist. No. 74

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Carroll

City or town Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months, 8 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 11 months, 8 days

## 3. (a) FULL NAME

BOYD FRANCIS MARTIN

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

single

6.(b) Name of husband or wife

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

1874

8. AGE:

Years

Months

Days

If less than one day

.....hrs. .....min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

laborer

lumber yards

MOTHER

FATHER

12. Name

Peter Martin

13. Birthplace

Maryland

14. Maiden name

Mary Bell Mason

15. Birthplace

16. Informant

Springfield State Hosp. records

Address

Sykesville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 6-14-47  
(month) (day) (year)

Cemetery or crematory

Redhouse

Location

Garrett Co., Md.

18. Funeral director

Herbert C. Brighton

Address

Oakland, Md.

19. Date rec'd by registrar

June 12 1947

C. Harry Blair

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Garrett

City or town Oakland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11

1947 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 3 1946 to June 11 1947

and that I last saw him alive on June 11 1947

Immediate cause of death

Arteriosclerosis

DURATION

Prior to 1946

Due to

Due to

Other conditions Psychosis with cerebral arteriosclerosis

(Include pregnancy within 3 months of death)

1 yr.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

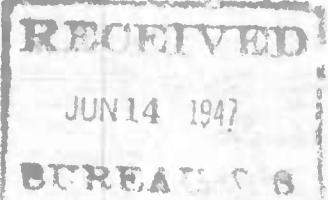
Injured at work?

23. SIGNATURE

Robert Bertrand May, M.D.

M. D. or other

Address Sykesville, Maryland Date signed 6-12-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

04920  
24  
24

Reg. Dist. No. 24

## CERTIFICATE OF DEATH

1. PLACE OF DEATH:  
County **Carroll**City or town **Rural near Sykesville**  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? **31 yrs., 11 m., 29 days**

Hospital, institution, or street address where death occurred:

**Springfield State Hospital**How long in hospital or institution? **31 yrs., 11 m., 29 days**

## 3. (a) FULL NAME

**FRED MATTHAI**4. Sex **male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **single**

6. (b) Name of husband or wife

...8. (c) If alive, give age **years**7. Birth date of deceased (mo. day, yr.) **July 13, 1869**8. AGE: Years **77** Months **11** Days **3** If less than one day **hrs. min.**9. Birthplace **Howard County, Maryland**  
(Town, county, and state)10. Usual occupation **none**

11. Industry or business

MOTHER FATHER 12. Name **Christian E. Matthai**  
13. Birthplace **Germany**14. Maiden name **Margaret Spielhaus**15. Birthplace **Germany**16. Informant **Springfield State Hosp. records**Address **Sykesville, Maryland**17. **Burial** Date thereof **6-18-47**  
(Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory **Baltimore Cem.**Location **Baltimore, Md.**18. Funeral director **Leonard S. Rach**Address **5305 Maryland Rd**19. **June 16 1947** C. Henry Clark  
(Date rec'd by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State **Maryland** CountyCity or town **Baltimore**  
(If outside city or town limits, write RURAL and give nearest town)Street No. **744 -**  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH **June 16, 1947** at **12:50 P.M.**

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

**May 1 1943** to **June 16 1947** and that I last saw him alive on **June 16**

Immediate cause of death

**Arteriosclerosis**

DURATION

**Prior to 1942**

Due to

Due to

Other conditions **Psychosis with mental deficiency**  
(Include pregnancy within 3 months of death)**34 yrs.**

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE **Robert Bertrand May, M.D.**  
M. D. or otherAddress **Sykesville, Maryland** Date signed **6-16-47**

RECEIVED

JUN 18 1947

BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

04921

1. PLACE OF DEATH: Carroll  
 County.....  
 City or town..... rural near Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death..... 12 years, 2 days  
 Hospital, institution, or street address where death occurred: Springfield State Hospital  
 How long in hospital or institution?..... 12 years, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... Maryland County.....  
 City or town..... Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3610 OLD FREDERICK Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... NONE

3. (a) FULL NAME  
 Daniel Edward McEntee

3. (b) Social Security Number  
 none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) September 9, 1887

8. AGE: Years	Months	Days	If less than one day
59	8	27	hrs. min.

9. Birthplace..... Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation..... grinder

11. Industry or business..... spectacle lenses

MOTHER FATHER 12. Name..... James McEntee

13. Birthplace..... Ireland

14. Maiden name..... Eliza Dunn

15. Birthplace..... Baltimore, Maryland

16. Informant..... Springfield State Hospital records

Address..... Sykesville, Maryland

17. Burial..... JUNE 9-1947  
 (Burial, cremation, or removal. Which?)

Cemetery or crematory..... NEW CATHEDRAL

Location..... BALTIMORE MD

18. Funeral director..... Hoff C. B. M. Walters

Address..... Pratt Street

19. (Date rec'd by registrar) 6/6 1947

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 6 1947 at 12:33 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 May 1 1943 to June 6 1947  
 and that I last saw him alive on June 5 1947

Immediate cause of death..... Acute cardiac decompensation  
 Due to..... Arteriosclerosis  
 Duration..... 6 days

Due to.....

Due to.....

Other conditions..... Schizophrenia, paranoid type  
 Duration..... 16 years  
 (Include pregnancy within 8 months of death)

Major findings or operations..... Date of op.

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D.  
 Springfield State Hospital  
 Sykesville, Maryland

Date signed..... 6-6-47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05460

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

Carroll  
Henryton

(If outside city or town limits, write RURAL and give nearest town)

1 month, 14 days

## How long in above place of death?

Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Maryland.

## How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Charles

City or town Rock Point

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

PARIS RICHARD MIDDLETON

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

Male

Colored

Single

## 6.(b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

March 27, 1917

## 6.(c) If alive, give age years

## 8. AGE:

Years      Months      Days      If less than one day  
30      2      24      hrs.      min.

## 9. Birthplace

Thomkinsville, Md.

(Town, county, and state)

## 10. Usual occupation

Oystering &amp; Fishing

## 11. Industry or business

12. Name

Charles H. Middleton

## 13. Birthplace

Unknown

## 14. Maiden name

Sarah Thomas

## 15. Birthplace

Unknown

## 16. Informant

Deceased

## Address

17. Burial Date thereof 6/23/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 6/20 1947

(Date rec'd by registrar)

Deputy Local Registrar

## 3. (b) Social Security Number

220-09-2919

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 20,

19 47

10.55A

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6, 19 47 to June 20, 19 47

and that I last saw h. i m alive on

June 20, 19 47

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

Jan.

1947

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

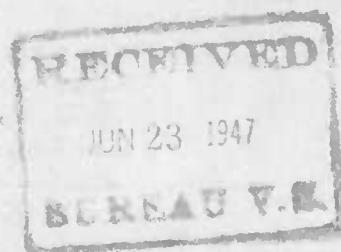
## Means of injury

Injured at work?

## 23. SIGNATURE

Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 6/20/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04922

Reg. Dist. No. 74

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

Carroll

County

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs. 6 mos. 4 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 19 yrs. 6 mos. 4 days

## 3. (a) FULL NAME

Fannie R. Moller

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March, 1895 (day unknown)

8. AGE: Years Months Days If less than one day

52 ? 3 ? hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Waitress

## 11. Industry or business

FATHER 12. Name Frederick Moller

13. Birthplace Baltimore, Maryland

14. Maiden name Julia Andrathy

15. Birthplace Baltimore, Maryland

16. Informant Record, Springfield State Hospital

Address Sykesville, Maryland

17. Burial Date thereof 6-17-47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Springfield Hosp. Cem.

Location Sykesville, Md.

18. Funeral director C. Harry E. Lee

Address Sykesville, Md.

19. Date rec'd by registrar June 17 1947 C. Harry Lee

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County City

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 517 East 35th Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

(DST)

20. DATE OF DEATH 6/12 19 47, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/41 19 to 6/12 19, and that I last saw her alive on 6/12 19 47.

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

Schizophrenia, Catatonic type  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

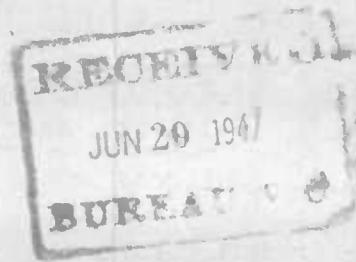
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichet, M.D.

M. D. or other

Address Sykesville, Maryland Date signed 6/12/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04923

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

## 1. PLACE OF DEATH:

County CarrollCity or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Albert D. Myers4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Gallusine J. Stanner6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years

Months

Days

If less than one day

hrs. min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Farm

11. Industry or business

MOTHER

FATHER

12. Name Daniel Myers13. Birthplace Gettysburg, Pa.14. Maiden name not known15. Birthplace ..16. Informant Charles F. MyersAddress Westminster, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 7-1947  
(month) (day) (year)Cemetery or crematory Widow CemeteryLocation Westminster, Md.18. Funeral director H. Bankard & SonAddress Westminster, Md.19. (Date record by registrar) 6-6-47Address Westminster, Md.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State  MarylandCounty CarrollCity or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. New Windsor Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

7001

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 7 1947 at 2 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 1947 to June 4 1947and that I last saw him alive on June 3 1947

Immediate cause of death

CardiacDURATION 1 hourDue to chronic myocarditis

4 yrs

Due to arterio-sclerosis

8 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

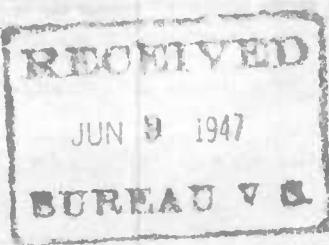
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: Charles R. Fout, M.D. M. D. or otherAddress Westminster, Md. Date signed 6-6-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04924

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

## 1. PLACE OF DEATH:

County CarrollCity or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 1 day

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumColored Branch, Henryton, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

VERNON NEEDUM

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

male colored

single

## 6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 31, 1909

## 8. AGE:

Years

Months

Days

If less than one day

3807

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Car Runner

## 11. Industry or business

12. Name Samuel Needum13. Birthplace Virginia14. Maiden name Maggie Fittchet15. Birthplace Virginia16. Informant Deceased

## Address

17. Burial (Burial, cremation, or removal, which?) Date thereof 6/11/47 (month) (day) (year)Cemetery or crematory Mt. Calvary

## Location

18. Funeral director Mrs. Katie K. WillianAddress 122 N. Schorer st19. 6/7 (Date rec'd by registrar)19. 47 Deputy Local

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1135 N. Stricker St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 194721. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 1947 to June 7, 1947,and that I last saw him alive on June 7, 1947.

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

Oct.1946

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md.Date signed 6/7/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1496

04925

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

## 1. PLACE OF DEATH:

County CarrollCity or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 3. (a) FULL NAME

Soldie Elizabeth Yess4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Paul J. Yess7. Birth date of deceased (mo., day, yr.) Aug 31, 19126. (c) If alive, give age 34 years

8. AGE:

Years 34Months 9Days 6

If less than one day

hrs.

min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Homemife

## 11. Industry or business

12. Name Harvey L. Yessauer13. Birthplace New Windsor, Md.14. Maiden name Annie L. Grimes15. Birthplace New Windsor, Md.16. Informant Paul J. YessAddress Westminster, Md. R.D. 517. Burial Burial Date thereof June 10 - 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Meadow Branch CemeteryLocation Westminster, Md.18. Funeral director H.B. Baird SonAddress Westminster, Md.19. 619 1947 Glendale  
(Date reg'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Westminster, Carroll Co. (If outside city or town limits, write RURAL and give nearest town)Street No. Uniontown Road (If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (b) Social Security Number

Zone 213-24-8925

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947 at 5:01 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1947, to June 7 1947and that I last saw her alive on June 7 1947Immediate causal death Pneumoniauterine & toxicShock hemorrhage

DURATION

2 hrs.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings or operations .....

Date of op.

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Date of .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

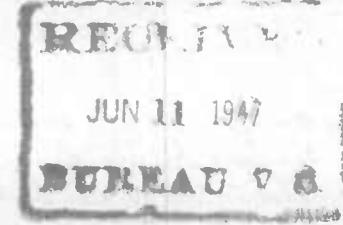
Means of injury .....

Injured at work?

23. SIGNATURE W. Gleason Peicher

M. D. or other

Address Westminster, Md. Date signed 6/9/47





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

138-  
04927

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll  
County.....

City or town..... Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 Mo's., 8 Days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

JOHN WESLEY SHAW

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Dorothy Shaw

7. Birth date of deceased (mo., day, yr.) March 27, 1905

8. AGE: Years 42 Months 2 Days 13 If less than one day hrs. min.

8. Birthplace..... Baltimore, Md.

(Town, county, and state)

10. Usual occupation..... Paper Hanger

11. Industry or business

12. Name..... William Shaw

13. Birthplace..... Maryland

14. Maiden name..... Blance Brown

15. Birthplace..... Baltimore, Md.

16. Informant..... Deceased

Address.....

17. Burial..... Burial Date thereof..... 6-13-47  
(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory..... Ardubur

Location..... Baltimore County

18. Funeral director..... Geo. G. Tolson

Address..... 1303 Preston St.

19. 6/9 1947 Albert R. Swankham

(Date rec'd by registrar) Deputy Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1734 N. Calhoun Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

217-18-1548

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 9, 1947 at 5:50P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 1, 1946, to June 9, 1947

and that I last saw him alive on June 9, 1947

Immediate cause of death..... Pulmonary Tuberculosis

Oct. 16, 1945

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

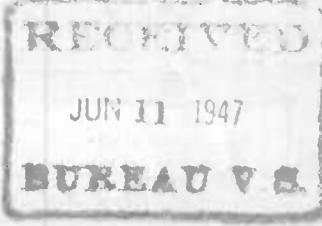
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Neleen Hoffmeyer, M.D.

M. D. or other

Address..... Henryton, Md. Date signed..... 6/9/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04928<sup>74</sup>

## CERTIFICATE OF DEATH

Reg. Dist. No. *134*

## 1. PLACE OF DEATH:

Carroll

County

Sykesville

City or town. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 15 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 3 mos. 15 days

## 3. (a) FULL NAME

LEO SINNOTT

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

single

6.(b) Name of husband or wife.

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) Dec. 5, 1904

8. AGE: Years Months Days If less than one day  
42 6 24 hrs. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Railroad

12. Name John Sinnott

13. Birthplace Ireland

14. Maiden name Margaret Murphy

15. Birthplace Ireland

16. Informant Hospital records

Address

17. Burial Date thereof 7/3/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral Cem

Location 4300 Old Patrick Road

18. Funeral director John J. Bowan &amp; Son

Address 901-03 Hallays Street

19. 7/30/47 1947 *AB* *Adm* *Don*  
(Date rec'd by registrar) (Date of death) (Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Baltimore

City or town. (If outside city or town limits, write RURAL and give nearest town)

Street No. 436 N. Robinson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

(DST)

20. DATE OF DEATH June 29, 1947 19 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1947 to June 29, 1947 and that I last saw him alive on June 29, 1947

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions Schizophrenia, Simple Type

1 yr

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arnold H. Sibert, M.D.

M. D. or other

Address S.S. Hospital, Sykesville, Md. Date signed 6-29-47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04929P

93d

BC

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 yrs 4 mos 30 days

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

2 yrs 4 mos 30 days

## 3. (a) FULL NAME

Anne Anna

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

715 W. Barre St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

W

Widowed

6.(b) Name of husband or wife

Snyder

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Dec. 20th 1863

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

Baltimore

10. Usual occupation

Practical nurse

11. Industry or business

Christian St. Schimoff

12. Name

Germany

13. Birthplace

Hollie Brooklock

14. Maiden name

Germany

15. Birthplace

Rev. Howard Braumley

16. Informant

405 Normandy Ave Baltimore

Address

17. Burial

Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

6/16/47

Cemetery or crematory

Trinity Cem.

Location

Baltimore, Md.

18. Funeral director

WM. J. TICKNER &amp; SONS

Address

Balto., Md.

19. (Date rec'd by registrar)

19 47

A. W. Hedrick

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

II

III

IV

V

VI

VS A15 9-45-15M

20. DATE OF DEATH

June 12th 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 11th 1945 to June 12 1947

and that I last saw her alive on June 12 1947

Immediate cause of death

Chronic Myocarditis

Due to

Arterio-Sclerous

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work

23. SIGNATURE

M. D. or other

Address

Date signed 6/12/47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04930

Reg. Dist. No. 74

## CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

T

1. PLACE OF DEATH:  
County..... Carroll  
City or town..... Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 months, 15 days

Hospital, institution, or street address where death occurred:..... Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Maryland.  
How long in hospital or institution?

## 3. (a) FULL NAME

FERNANDO STANCIL

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... April 26, 1900

8. AGE:	Years	Months	Days	It less than one day
	47	1	13	hrs. min.

9. Birthplace..... Greenville, N. C.  
(Town, county, and state)

10. Usual occupation..... Daryman

11. Industry or business.....

12. Name..... Fernando Stancil, Sr.
13. Birthplace..... North Carolina

14. Maiden name..... Louisa Teel
15. Birthplace..... Greenville, N. C.

16. Informant..... Deceased

Address.....

17. Burial Date thereof..... 6-11-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Pitt Co.

Location..... Greenville, N. C.

18. Funeral director..... Flanagan &amp; Parker

Address..... Greenville, N. C.

19. 6/8 1947 Albert R. Seward  
(Date rec'd by registrar) Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Clarksburg  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

218-05-5218

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 8, 1947, at 6.00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 24, 1946, to June 8, 1947, and that I last saw him alive on June 8, 1947.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION

Sept.

1946

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

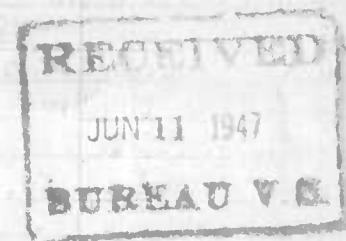
Means of injury..... Injured at work?

23. SIGNATURE..... Robert Hoffmann, M.D.

M. D. or other

Address..... Henryton, Md.

Date signed..... 6/8/47



1. PLACE OF DEATH: Carroll  
 County.....  
 City or town..... Sykesville.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 27 yrs. 3 mos. 27 days  
 Hospital, Institution, or street address where death occurred: Springfield State Hospital  
 How long in hospital or institution? 27 yrs. 3 mos. 27 days

## 1. PLACE OF DEATH:

Carroll

County.....

City or town.....

Sykesville.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs. 3 mos. 27 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 27 yrs. 3 mos. 27 days

## 3. (a) FULL NAME

Ernestine Staples

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	Married

6. (b) Name of husband or wife..... Fritz Staples

7. Birth date of deceased (mo., day, yr.) 1884 (day + month unknown) 6. (c) If alive, give age..... years

8. AGE: Years Months Day If less than one day  
63                hrs.      min.9. Birthplace..... Unknown  
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business

12. Name..... Unknown

13. Birthplace

14. Maiden name..... Unknown

15. Birthplace

## 16. Informant..... Hospital Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof..... 6-5-47  
(month) (day) (year)

Cemetery or crematory

Location..... Baldy End.

18. Funeral director..... William Cook, Inc.

Address..... 1217 1/2 Paul St.

19. June 5 1947 C. Harry Green  
(Date rec'd by registrar) Registrar

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04931

## CERTIFICATE OF DEATH

RC

74

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 502 Brunswick Street  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 4 1947 at 1:00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 16 1941 to June 4 1947

and that I last saw her alive on June 4 1947

Immediate cause of death.....

Pulmonary Tuberculosis

Due to.....

Due to.....

Other conditions.....

Ach. gaster. feb. type  
(Include pregnancy within 3 months of death)

28 yrs.

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Arnold H. Eichut M.D.

M.D. or other

Address..... Sykesville, Md. Date signed 6-8-47

RECEIVED

JUN 9 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

04932

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

## 1. PLACE OF DEATH.

County CarrollCity or town Rural - Westminister

(If outside city or town limits, write RURAL and give nearest town)

5 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

D. Raymond Stuller

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteMarried

6. (b) Name of husband or wife

N. Grace Stuller

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age 54 years

Sept. 12, 1890

8. AGE:

Years

Months

Days

If less than one day

56

9

15

. hrs. . min.

9. Birthplace

Carroll Co. Maryland

(Town, county, and state)

10. Usual occupation

Sellman

11. Industry or business

Montgomery Ward Co.

MOTHER FATHER

12. Name

Jesse Stuller

13. Birthplace

Maryland

14. Maiden name

Leannah Lindsay

15. Birthplace

Maryland

16. Informant

Mrs. H. Grace Stuller

Address

Westminister Md

17. Burial

Date thereof 6-30-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or repository

Meadow Branchnear Westminister Carroll Co. Md.

18. Funeral director

C. W. Walz

Address

Linfield Md.

19. (Date rec'd by registrar)

6/29/47 Raymond

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarrollCity or town Rural - Westminister

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

220-18-1138

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1947 to June 27 1947

and that I last saw him alive on June 27 1947.

Immediate cause of death

Pneumonia

DURATION

10 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

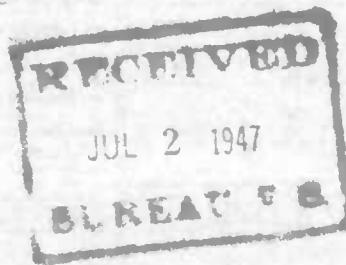
James T. Thank M.D.

M. D. or other

Westminister Md

Date signed

6/28/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

04933  
82

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County

Carroll

City or town

New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Bertha Maude Swardbaugh

## 3. (b) Social Security Number

7001

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Charles E. Swardbaugh

7. Birth date of deceased (mo., day, yr.)

March 4 - 1875

6. (c) If alive, give age years

8. AGE:

Years      Months      Days      If less than one day  
72      3      14      hrs.      min.

9. Birthplace

Wardboro, Fred. Co. Md.

(Town, county, and state)

10. Usual occupation

7001

11. Industry or business

William Wilson

12. Name

William Wilson

13. Birthplace

Frederick Co. Md.

14. Maiden name

Not known

15. Birthplace

..

16. Informant

Mrs. William Lovell

Address

New Windsor, Md.

17. Burial

Date thereof June 20, 1947

(month) (day) (year)

Cemetery or crematory

Westminster Cemetery

Location

Westminster, Md.

18. Funeral director

H. Bankard Son

Address

Westminster, Md.

Date rec'd by registrar

June 20

1947

Great Bend

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 18, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20 - 1947, to June 18, 1947

and that I last saw h. alive on June 17 - 1947

Immediate cause of death

Diabetes  
Myocarditis (ch)  
Hypertension (ch -)

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

None

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. C. Jernette, M.D.

M. D. or other

Address

Westminster, Md.

Date signed

6-18-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly. M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04934

83a  
Be

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Carroll

City or town Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs., 11 mon., 9 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 5 yrs., 11 mon., 9 days

## 3. (a) FULL NAME

JOHN WAGNER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	widowed

6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 25, 1862

8. AGE: Years	Months	Days	if less than one day
84	8	17	hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation storekeeper

11. Industry or business

12. Name Francis Maximillion Wagner

13. Birthplace Germany

14. Maiden name Elizabeth Catherine Houst

15. Birthplace Germany

16. Informant Springfield State Hosp. records

Address Sykesville, Maryland

17. Burial Date thereof June 19, 1947  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory New Cathedral Cemetery

Location 4300 Old Frederick Rd.

18. Funeral director John W. Conklin &amp; Son

Address 924 E. Eager St. Baltimore 2 Md

19. 6/13/47 G.W. Frederich

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1218 Eager Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to June 11 1947

and that I last saw him alive on June 11 1947

Immediate cause of death Cerebral hemorrhage

Due to Arteriosclerosis

Due to

Other conditions Senile psychosis, simple deterioration

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert Bertrand May, M.D.

M. D. or other

Address Sykesville, Maryland Date signed 6-12-47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04935

Reg. Dist. No. 74

## CERTIFICATE OF DEATH

93d

1. PLACE OF DEATH: Carroll  
 County.....  
 City or town..... Flohrville  
 (If outside city or town limits, write RURAL and give nearest town)  
 33 years  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 Maryland Carroll  
 State..... County.....  
 City or town..... Flohrville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Rural--Sykesville  
 (If rural, give LOCATION)

3. (a) FULL NAME  
 LESTER J. WALTZ

3. (b) Social Security Number

4. Sex  
 Male      5. Color or race  
 White      6. (a) Single, married, widowed, or divorced  
 Married  
 Gertrude B. Waltz

8. (b) Name of husband or wife.....  
 67 years  
 7. Birth date of  
 deceased (mo., day, yr.) Dec. 5, 1883

8. AGE:      63      9. Birthplace  
 Years      Months      Days      If less than one day  
 5      26      hrs.      min.

Maryland  
 9. Birthplace.....  
 (Town, county, and state)  
 Painter

10. Usual occupation.....  
 Painter

11. Industry or business  
 John Preston Waltz  
 12. Name.....  
 Maryland

MOTHER FATHER  
 13. Birthplace  
 Maryland

MARY JANE RECK  
 14. Maiden name.....  
 Maryland

Mrs. Gertrude B. Waltz  
 15. Birthplace  
 Sykesville, Md.

18. Informant  
 Burial  
 (Burial, cremation, or removal. Which?) Date thereof..... 6-4-47

Cemetery or crematory.....  
 Deer Park  
 Location..... Smallwood, Carroll Co. Maryland

18. Funeral director  
 C. M. Waltz  
 Address..... Winfield, Md.

19. June 3 1947  
 (Date rec'd by registrar) C. Harry Weller  
 Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 1, 1947 8:15P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 1946 to 1947 and that I last saw him alive on June 1, 1947.

Immediate cause of death.....

Cardiac vascular disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

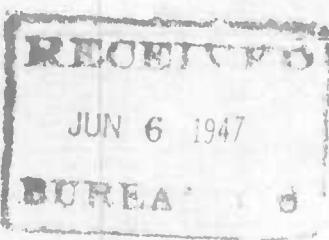
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE  
 M. D. or other

Address..... C. Harry Weller Date signed 6-4-47



04936

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diet. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Type correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

Carroll County

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 8 mo's, 24 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

HAZEL ARLETTA WATERS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female colored single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 22, 1924

8. AGE:

Years

Months

Days

If less than one day

23

3

5

hrs.

min.

9. Birthplace

Nanticoke, Md.

(Town, county, and state)

10. Usual occupation

Factory Worker

11. Industry or business

MOTHER FATHER

Robert Waters

13. Birthplace

Maryland

14. Maiden name

Annie E. Barkley

15. Birthplace

Maryland

16. Informant

Deceased

Address

17. Burial Date thereof 6-30 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Nanticoke

Location

Md.

18. Funeral director

C. J. Messick

Address

Riverview, Md.

19. 6/27

(Date rec'd by registrar)

19 47

Albert R. Savannah

Deputy Local

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Nanticoke (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

219-14-2679

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947, at 10.55 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 3, 1943, to June 27, 1947,

and that I last saw her alive on June 27, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

May 1943

Due to

Died to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Name of injury

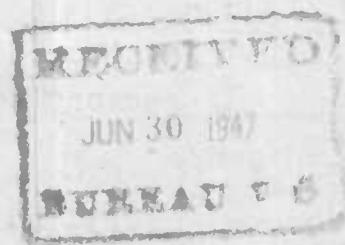
Injured at work?

23. SIGNATURE

Robert Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 6/27/47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04937

93d

RC  
Reg. Dist. No. 74

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

Carroll

County

City or town

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs. 8 mos. 23 days.

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 21 yrs. 8 mos. 23 days.

## 3. (a) FULL NAME

BERTHA WEBSTER

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

white

married

6.(b) Name of husband or wife

Joseph Webster

7. Birth date of deceased (mo., day, yr.)

January 28, 1865

6.(c) If alive, give age ? years

8. AGE:

Years	Months	Days	If less than one day
82	5	1	hrs. min.

9. Birthplace

Baltimore Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name

Charles Bauer

13. Birthplace

Germany

14. Maiden name

Mary Richenberger

15. Birthplace

Maryland

16. Informant

hospital records

Address

17. *Revised Burial* Date thereof June 30-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Mt. Olivet

Location

Baltimore Md.

18. Funeral director

Wm. Cook Jr.

Address

121 St Paul Baltimore, Md.

19. June 30 1947

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1531 Poplar Grove St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

(DST)

20. DATE OF DEATH June 29 1947 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 16, 1941 19 to June 29 1947, to June 29 1947.

and that I last saw her alive on June 29 1947.

Immediate cause of death

Chronic Myocarditis

Due to Arteriosclerosis

Due to

Other conditions Epilepsy

unkn.

unkn.

unkn.

unkn.

75 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

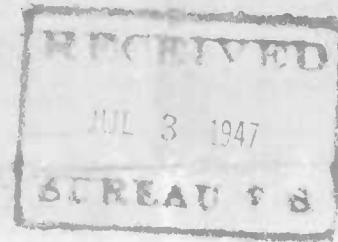
23. SIGNATURE

Arnold H. Gilbert M.D.

M. D. or other

Address S.S. Hospt. Sykesville, Md.

Date signed 6-29-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04938

## CERTIFICATE OF DEATH

138  
Reg. Dist. No. 74

## 1. PLACE OF DEATH:

Carroll

County

Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 796 W. Saratoga St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

JOSEPH WILSON

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec., 22, 1903

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
43 6 3 hrs. min.

9. Birthplace Norfolk, Va.

(Town, county, and state)

10. Usual occupation Stevedore

11. Industry or business

12. Name Joe Wilson

13. Birthplace Unknown

14. Maiden name Mary ?

15. Birthplace Virginia

16. Informant Deceased

Address

17. Burial Date thereof June 23-47  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Mt. Auburn

Location Baltimore City

18. Funeral director Geo S. Kelton

Address 1303 Preszman St.

19. 6/25 1947 Albert Swanson  
(Date rec'd by registrar) Deputy Local Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1947, at 2.15A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23, 1947, to June 25, 1947, and that I last saw him alive on June 25, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

March 1947

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

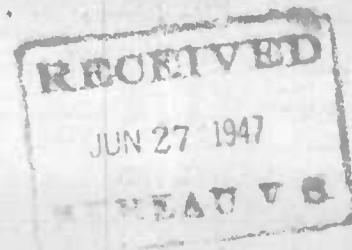
Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address Henryton, Md. Date signed 6/25/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04939  
Reg. Date, No. 74

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

Carroll

County

Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution:

## 3. (a) FULL NAME

LUZELL WITHERSPOON

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male colored single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

Dec., 24, 1929

8. AGE: Years Months Days If less than one day  
17 6 0 hrs. min.9. Birthplace Manning, S. C.  
(Town, county, and state)

10. Usual occupation Factory Worker

11. Industry or business

12. Name Carlee Witherspoon

13. Birthplace Unknown

14. Maiden name Closanna Felder

15. Birthplace South Carolina

16. Informant Deceased

Address

17. Burial Date thereof June 28 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Calvary Cem.

Location

18. Funeral director Sarah L Brown Son

Address 108 W Montgomery St

19. 6/24 1947 Albert R. Safenbauer  
(Date rec'd by registrar) Deputy Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 657 W. Lee Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

219-22-4377

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947 at 2.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 8, 1947, to June 24, 1947,

and that I last saw him alive on June 24, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Feb. 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md.

Date signed 6/24/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04940

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

Carroll

County Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 9 Mo's, 15 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

HAZEL LOUISE YOUNG

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female colored married

6. (b) Name of husband or wife

Nathaniel Young

7. Birth date of deceased (mo., day, yr.)

March 21, 1926

6. (c) If alive, give age 22 years

8. AGE:

Years 21 Months 2 Days 21 If less than one day hrs. min.

9. Birthplace

Wolfords, Md.

(Town, county, and state)

10. Usual occupation

Canning Factory

11. Industry or business

MOTHER FATHER

12. Name

Raymond Holliday

13. Birthplace

Williamsburg, Md

14. Maiden name

Elizabeth Coston

15. Birthplace

Wolfords, Md.

16. Informant

Patient

Address

417 Pine St

17. Burial

Date thereof June 15/47

(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Cambridge, Md.

18. Funeral director

David A. Baysneur

Address

201 Washington St, Carroll

19. 6/11

19

47

(Date rec'd by registrar)

Deputy Local

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 Pine Street

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

216-18-2545

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 11, 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 27, 1945, to June 11, 1947,

and that I last saw her alive on June 11, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

March

1945

Duo to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

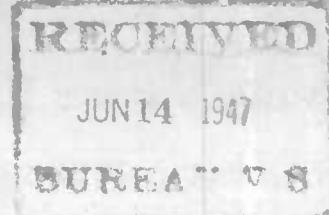
Robert Hoff

M. D. or other

Address

Henryton, Md

Date signed 6/11/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04941

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County

Carroll  
Manchester, Md. RuralCity or town  
(If outside city or town limits, write RURAL and give nearest town)

Life.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Near Melrose

How long in hospital or institution?

## 3. (a) FULL NAME

Clarence Roland Zepf

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Married

6. (b) Name of husband or wife

Grace Lester Zepf 55

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) March 7, 1888

8. AGE:

Years

Months

Days

If less than one day

59

3

19

hrs. min.

9. Birthplace: Manchester, Maryland

(Town, county, and state)

10. Usual occupation: Merchant

State Roads, Corr.

(Lumber) Young Zepf.

11. Industry or business

12. Name: Charles Young Zepf.

13. Birthplace

Maryland

14. Maiden name: Emma Price

15. Birthplace

Maryland

16. Informant: Mrs. Clarence Zepf

Address: Manchester, Md.

17. Burial Cemetery

Date thereof: 6-29-47

(Burial, cremation, or removal, if applicable)

(month) (day) (year)

Cemetery or crematory: Cemetery

Location: Manchester, Md.

18. Funeral director: Jacob Willis &amp; Sons

Address: Manchester, Md.

19. Date rec'd by registrar: June 28, 1947

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester, Md. Rural

Street No: Melrose

(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (b) Social Security Number

220-10-5636

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26, 1947, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12, 1947, to June 26, 1947, and that I last saw him alive on June 25, 1947.

Immediate cause of death:

Coronary Thrombosis 14 Da.

Due to: Coronary Thrombosis?

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide:

Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph E. Bush, M.D.

M. D. or other

Address: 100 Park Plaza, Date signed: 6-26-47

